Federal Fiscal Year 2001
FRAMEWORK FOR ANNUAL REPORT
OF STATE CHILDREN S HEALTH INSURANCE PLANS
UNDER TITLE XXI OF THE SOCIAL SECURITY ACT

Preamble
Section 2108(a) of the Act provides that the State must assess the operation of the State child health plan in each fiscal year, and report to the Secretary, by January 1 following the end of the fiscal year, on the results of the assessment. In addition, this section of the Act provides that the State must assess the progress made in reducing the number of uncovered, low-income children.

To assist states in complying with the statute, the National Academy for State Health Policy (NASHP), with funding from the David and Lucile Packard Foundation, has coordinated an effort with states to develop a framework for the Title XXI annual reports.

The framework is designed to:

Recognize the ***diversity*** of State approaches to SCHIP and allow States ***flexibility*** to highlight key accomplishments and progress of their SCHIP programs, **AND**

" Provide ***consistency*** across States in the structure, content, and format of the report, **AND**

" Build on data ***already collected*** by CMS quarterly enrollment and expenditure reports, **AND**

" Enhance ***accessibility*** of information to stakeholders on the achievements under Title XXI.

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FRAMEWORK FOR ANNUAL REPORT
OF STATE CHILDREN S HEALTH INSURANCE PLANS
UNDER TITLE XXI OF THE SOCIAL SECURITY ACT

State/Territory: Mississippi
(Name of State/Territory)

The following Annual Report is submitted in compliance with Title XXI of the Social Security Act (Section 2108(a)).

(Signature of Agency Head)

SCHIP Program Name (s) **MS Health Benefits Program (MHB)**

SCHIP Program Type ____ Medicaid SCHIP Expansion Only
____ Separate SCHIP Program Only
__x__ Combination of the above

Reporting Period **Federal Fiscal Year 2001 (10/1/2000-9/30/2001)**

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Submission Date **01/31/02**

(Due to your CMS Regional Contact and Central Office Project Officer by January 1, 2002)
Please cc Cynthia Pernice at NASHP (cpernice@nashp.org)

SECTION 1. DESCRIPTION OF PROGRAM CHANGES AND PROGRESS

This sections has been designed to allow you to report on your SCHIP program changes and progress during Federal fiscal year 2001 (September 30, 2000 to October 1, 2001).

1.1 Please explain changes your State has made in your SCHIP program since September 30, 2000 in the following areas and explain the reason(s) the changes were implemented.

Note: If no new policies or procedures have been implemented since September 30, 2000, please enter NC for no change. If you explored the possibility of changing/implementing a new or different policy or procedure but did not, please explain the reason(s) for that decision as well.

A. **Program eligibility**

Self-declaration of age was implemented October 2000. Copies of birth certificates or other birth records are no longer required to accompany the application. In October 2000, the six month waiting period for eligible children with prior creditable health insurance was also eliminated. Optional self declaration of income was implemented in April 2001. Parents living in the household with the applicants have a choice of providing their social security numbers for verification of their income or provide proof of the most month s income.

B. Enrollment process

In April 2001 the twenty dollar ($20) incentive for each child enrolled in MHB was expanded to include Head Start programs along with public schools.

C. Presumptive eligibility

Mississippi s state plan amendment to implement presumptive eligibility (PE) was submitted in July and approved by the Center for Medicare and Medicaid Services (CMS) in October with an effective date of July 01, 2001. PE is scheduled to be implemented on a pilot basis in January 2002 and going statewide late April 2002.

D. Continuous eligibility N/C

E. Outreach/marketing campaigns

The existing outreach and enrollment contract that was established with Catholic Charities Children s Health Matters was continued in July 2001. The Division of Medicaid (DOM) has established formal agreements and contacts with the Catholic Diocese of Jackson and Regugee and Hispanic and Vietnamese Ministry of Biloxi to assist with outreach and enrollment, the translation of materials and the cultural sensitivity of language relative the Hispanic and Vietnamese populations. The MHB application is available in Vietnamese and Spanish.

In April 2001 DOM along with Catholic Charities Children s Health Matters facilitated a statewide outreach and enrollment blitz. Prior to the blitz twenty-one (21) regional training meetings were conducted and local coordinators identified.

F. Eligibility determination process

In the eligibility process, any child support related activities were totally de-linked from the application procedures. The establishment of paternity for medical child support services is available if the parent requests it. But a parent (other than a pregnant woman) applying for health benefits must cooperate with child support activities in order to receive benefits for him/herself.

G. Eligibility redetermination process

The state implemented passive re-determination in June 2001. This renewal process involved sending the family a total of three notices advising the parent/care giver to sign and return if information provided has not changed, or indicate the changes, sign and return it. The first notice is sent forty-five (45) days prior to the annual renewal. If no response is received by the tenth (10) day, the second notice is sent. Then final notice is sent ten days thereafter with a termination date.

H. Benefit structure

During the 2001 Legislative Session, legislation was passed authorizing the expansion dental coverage in CHIP Phase II which was effective January 1, 2002. The expanded dental benefits include some restorative, endodontic, periodontic, and surgical dental services.

I. Cost-sharing policies N/C

J. Crowd-out policies

As a provision in the state plan amendment to eliminate the 6-month waiting period, the state is required to monitor the number of children enrolled in MHB who have had health insurance coverage in the last six months. When that number exceeds 15% of the number of children enrolled since October 2001, the state must implement a crowd-out mechanism.

K. Delivery system

Under CHIP Phase II, the established vision network for routine vision services was expanded to include more providers in early 2001 which improved access in all areas. As a result state legislation, HB444, that was passed in the 2001 Legislative Session authorizing the establishment of a dental provider network, the contact insurer recruited and credentialed dentists for participation in the dental network. The effective date for the implementation of the dental provider network along with the dental benefits expansion is January 01, 2002.

L. Coordination with other programs (especially private insurance and Medicaid)

N/C

M. Screen and enroll process N/C

N. Application

In April 2001, the application for MHB was revised. This revision included (1) addition of a question regarding the language most-often spoken in the home, (2) the self-declaration of age, (3) the optional self-declaration of income, (4) elimination of question regarding the absent parent, and (5) added information regarding child support services.

O. Other

1.2 Please report how much progress has been made during FFY 2001 in reducing the number of uncovered, low-income children.

A. Please report the changes that have occurred to the number or rate of uninsured, low-income children in your State during FFY 2001. Describe the data source and method used to derive this information.

According to the US Census Bureau, Census 2010 report there is a total of 776,592 children 0-18 years of age in Mississippi. As of October 30, 2001, 359,102 children under 19 years of age were receiving health benefits through Medicaid or SCHIP according to compiled enrollment data reports from the Division of Medicaid (DOM) and the Department of Human Services (DHS). Forty-eight thousand, two hundred and three (48,203) of the 359,102 children were enrolled on SCHIP (6595 CHIP I and 41,608 CHIP II).

B. How many children have been enrolled in Medicaid as a result of SCHIP outreach activities and enrollment simplification? Describe the data source and method used to derive this information.

Of the 359,102 children enrolled in health benefits as of 10/30/01, 310,899 were receiving Medicaid benefits reflecting increase of 77,210 children since CHIP Phase I was implemented in July, 1998. This data also indicates that children are still being approved at a rate of 2 Medicaid to every 1 CHIP.

C. Please present any other evidence of progress toward reducing the number of uninsured, low-income children in your State.

In March 2001 a second assessment was done to identify children whose TANF cases closed between October 1, 1996 and September 30, 1999. Approximately 21, 000 children were identified still without health benefits from the original pool of about 30,000. The families of these children were notified by mail that their children s Medicaid benefits would be automatically re-instated for 120 days. In order for benefits to continue after that time, they would need to complete a MHB application and be approved according to the current eligibility criteria. About 1700 families responded and have remained active past the 120 days.

D. Has your State changed its baseline of uncovered, low-income children from the number reported in your March 2000 Evaluation?

__X__ No, skip to 1.3

____ Yes, what is the new baseline?

What are the data source(s) and methodology used to make this estimate?

What was the justification for adopting a different methodology?

What is the State s assessment of the reliability of the estimate? What are the limitations of the data or estimation methodology? (Please provide a numerical range or confidence intervals if available.)

Had your state not changed its baseline, how much progress would have been made in reducing the number of low-income, uninsured children?

The State has not changed its baseline. But the State has been awarded a Robert Wood Johnson Foundation State Coverage Initiative Grant. The focus of this grant is to do an assessment of the current data sources on the projected number of uninsured in the State and research feasible options of expansion of coverage. The final report from this one year grant may support a change in the State s baseline at that time.

1.3 Complete Table 1.3 to show what progress has been made during FFY 2001 toward achieving your State s strategic objectives and performance goals (as specified in your State Plan).

In Table 1.3, summarize your State s strategic objectives, performance goals, performance measures and progress towards meeting goals, as specified in your SCHIP State Plan. Be as specific and detailed as possible. Use additional pages as necessary. The table should be completed as follows:

Column 1: List your State s strategic objectives for your SCHIP program, as specified in your State Plan.
Column 2: List the performance goals for each strategic objective.
Column 3: For each performance goal, indicate how performance is being measured, and progress towards meeting the goal. Specify data sources, methodology, and specific measurement approaches (e.g., numerator, denominator). Please attach additional narrative if necessary.

Note: *If no new data are available or no new studies have been conducted since what was reported in the March 2000 Evaluation, please complete columns 1 and 2 and enter NC (for no change) in column 3.*

Table 1.3		
(1) Strategic Objectives (as specified in Title XXI State Plan and listed in your March Evaluation)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify data sources, methodology, time period, etc.)
OBJECTIVES RELATED TO REDUCING THE NUMBER OF UNINSURED CHILDREN		
Reduce the percentage of low-income children without health insurance	By July 1, 1998 to enhance the infrastructures of DOM and DHS to meet the target of enrolling 15,000 children under CHIP Phase I, i.e., data management, eligibility determination, health status and service utilization modifications, staff training and publications.	Data Sources: Division of Medicaid (DOM) and Department of Human Services (DHS) data management systems Methodology: Information provided is based internal review of the agencies enrollment data thru September 30, 2001. Progress Summary: As of September 30, 2001 6595 children were enrolled in CHIP Phase I. The number of children enrolled in CHIP I during FFY 2001 has shown a consistent decrease as these are aging out of the program or rolling into regular Medicaid. In July 2001 DHS installed a new Health Benefits Sub-system that enhanced their capability to give more accurate enrollment and case management data. At least four regional trainings for the public has been conducted statewide. Two revisions were made in the MHB application in an effort to simplify the application process and eliminate eliciting un-needed information. Program information, updates and publications continues to be distributed through the county DHS and health department offices, DOM regional offices, Head Start, public schools, advocacy, community and faith-based organizations.
OBJECTIVES RELATED TO SCHIP ENROLLMENT		
Enroll all eligible children in MHB	Outreach activities will be re-evaluated; materials developed and distributed statewide on-going. Define specific outreach activities to target and enroll ethnic minorities and/or targeted groups.	Data Sources: DOM and DHS enrollment data and activity reports Methodology: Number of children enrolled in all health benefits program are reviewed on a monthly basis. Information given was secured from data and activity reports submitted through September 30, 2001. Progress Summary: In coordination with Children s Health Matters/Catholic Charities, DOM orchestrated a statewide outreach and enrollment blitz in April. This involved conducting four regional meeting that resulted in the

Table 1.3		
(1) Strategic Objectives (as specified in Title XXI State Plan and listed in your March Evaluation)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify data sources, methodology, time period, etc.)
		identification of 21 regional coordinators. These community coordinators took the leadership role in developing specific outreach activities for their communities. In April 2001 Head Start programs were added to the Outreach Incentive Initiative along with public schools. In July 2001 DOM developed a Limited English Proficiency Plan to insure that all services were accessed to all clients regardless to their inability to speak to English. In July 2001 DOM established a contract with an private company to evaluate the effectiveness of outreach activities and initiatives. Some of the results from that evaluation report are: The need to informed about the Program from several sources before enrollment was evident regardless to demographics. Of the respondents who knew about the hotline found it to be useful. Personal contact strategies (face to face interactions with informed persons) were considered more effective in stimulating enrollment than non-personal contacts (e.g. radio, TV). Media campaign need to target people and local places people identify with and can relate to.
OBJECTIVES RELATED TO INCREASING MEDICAID ENROLLMENT		
Increase the number of Medicaid-eligible children enrolled in Medicaid	By September 30, 2001 90,000 previously un-insured children will have health benefits (Medicaid or CHIP).	Data Sources: DOM and DHS enrollment data reports Methodology: Monthly review of enrollment data reports Progress Summary: In July 1998 182,198 children were enrolled in Medicaid. As of September 30,2001 359,102 were enrolled in health benefits - CHIP I 6595; 41,608 CHIP II reflecting a net increase of 128,601 in regular Medicaid.
OBJECTIVES RELATED TO INCREASING ACCESS TO CARE (USUAL SOURCE OF CARE, UNMET NEED)		
Ensure all children enrolled MHB have access to health care.	By September 2001 85% of children enrolled in CHIP I enrollees will have a medical home; at least 90% of CHIP II enrollees will have access to a primary care provider within 25 miles of their homes.	Data Sources: DOM, DHS and Department of Finance and Administration (DFA) Methodology: Review and cross match of enrollment, claim and/or utilization data. Progress Summary: HealthMacs, a form of managed care, is mandatory for Medicaid-enrolled children. Children approved for Medicaid is assigned a primary care provider within 2 months after enrollment. As of FFY 2001, about _90% of the children receiving Medicaid-eligible is enrolled in Managed Care.

Table 1.3		
(1) Strategic Objectives (as specified in Title XXI State Plan and listed in your March Evaluation)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify data sources, methodology, time period, etc.)
		For CHIP II enrollees, the delivery system is contracted through a fully insured health plan with an established commercial provider network. This network is inclusive of all specialty provider types, and approximately 80% of Mississippi physicians and hospitals participate in the network. The insurer contracts with providers in community health center, rural health centers and school-based clinics. One hundred percent (100%) of enrolled children have access to primary care provider within 25 miles.
OBJECTIVES RELATED TO USE OF PREVENTIVE CARE (IMMUNIZATIONS, WELL-CHILD CARE)		
MHB will improve the health status of children enrolled in health benefits.	The State will continue to work on the development of a formal data management system to focus on established performance goals of the target population.	Data Sources: DOM and DFA Methodology: Mississippis Management Information Retrieval System (MMIRS) provide on-line age specific utilization data on MBH Medicaid. DFA will be responsible for securing likewise utilization data from the Contractor. Progress Summary: The State has conducted an assessment of the number of Medicaid beneficiaries who have received periodic screens over several years. This assessment revealed that the percentage of Medicaid-eligible 21 and under screened according to schedule has ranged form an all-time high in 1998 to all-time high of 84 % to all-time low of 35% in 2000. Following this assessment, a corrective plan of action was developed. Its overall goal is to increase EPSDT screen services for Medicaid-eligible 21 years and under screening ratio to 60% or greater by 2003. This plan is being implemented through the coordination and collaboration of intra-agency bureaus and related external partners (e.g. Head Start, Department of Health, community health and rural health centers, and other private providers. This Bureau also has two qualified nurses who monitor the quality of care and conduct periodic records and case review at providers offices. They provide follow-up on alleged non-compliance and outreach education. DOM has employed 25 client field representatives (CFR). The primary function of the CFRs is to educate providers and beneficiaries about the Program and its benefits. Each CFR has contact (phone, face-to-face, in community agencies, at community events, etc.) with approximately 1500 Medicaid beneficiaries per month. Relative to the children enrolled in CHIP II, preliminary utilization data from the insurer show that 68% of children

Table 1.3		
(1) Strategic Objectives (as specified in Title XXI State Plan and listed in your March Evaluation)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify data sources, methodology, time period, etc.)
		enrolled for just one month have received health care from at least one source. The longer the child is enrolled, the higher the rate of those seeking care: 80% of those enrolled for six months and 86% of children enrolled for twelve months received some type of health care service. (See graph for utilization statistics.) From a match of CHIP enrollment data and the State Immunization Registry, 87% of children enrolled in CHIP had completed the required set of childhood immunization by 2 years of age. A summary of the Member Satisfaction Survey showed relatively high satisfaction rate for enrollees: 93.2% satisfaction with claim service, 94% with customer service and 93.8% with provider access. A Member Satisfaction Survey is conducted annually. A contract has established with a data management vendor that will generate various utilization reports and provide more detailed information on quality indicators.
OTHER OBJECTIVES		
		Data Sources: Methodology: Progress Summary:

1.4 If any performance goals have not been met, indicate the barriers or constraints to meeting them. N/A

1.5 Discuss your State s progress in addressing any specific issues that your state agreed to assess in your State plan that are not included as strategic objectives. N/A

1.6 Discuss future performance measurement activities, including a projection of when additional data are likely to be available.

The State will continue to refine its data management system. A Data Management Team has been formed consisting of DOM staff from Managed Care, Maternal Child Health, Executive Services, Systems and CHIP as well CHIP staff from DFA. The one of the ultimate goals of the Team is to establish standard performance measures for both Medicaid and CHIP enrollees.

1.7 Please attach any studies, analyses or other documents addressing outreach, enrollment, access, quality, utilization, costs, satisfaction, or other aspects of your SCHIP program s performance. Please list attachments here.

- Member Satisfaction Survey
- Mississippi Health Benefits Program Outreach Evaluation Report

SECTION 2. AREAS OF SPECIAL INTEREST

This section has been designed to allow you to address topics of current interest to stakeholders, including; states, federal officials, and child advocates.

2.1 Family coverage: N/A

A. If your State offers family coverage, please provide a brief narrative about requirements for participation in this program and how this program is coordinated with other program(s). Include in the narrative information about eligibility, enrollment and redetermination, cost sharing and crowd-out.

B. How many children and adults were ever enrolled in your SCHIP family coverage program during FFY 2001 (10/1/00 - 9/30/01)?

Number of adults_____
Number of children_____

C. How do you monitor cost-effectiveness of family coverage?

2.2 Employer-sponsored insurance buy-in:

A. If your State has a buy-in program, please provide a brief narrative about requirements for participation in this program and how this program is coordinated with other SCHIP program(s).

The State s plan to implement employer-sponsored insurance buy-in was approved. An implementation date has not been identified at this time.

B. How many children and adults were ever enrolled in your SCHIP ESI buy-in program during FFY 2001?

Number of adults_____
Number of children_____

2.3 Crowd-out:

A. How do you define crowd-out in your SCHIP program?

Crowd-out is defined as the point time where the number of children enrolled in MHB who have had previous creditable health insurance in the last six months is 15% of the total enrollment as of 10/01/2000, which was when the 6-month waiting period was eliminated.

B. How do you monitor and measure whether crowd-out is occurring?

C. The State is monitoring on a monthly basis the number of children enrolled in the CHIP II Program who have had creditable health insurance in the last 6 months. When this number equals to 15% of the total enrollment since 10/01/2000, the State will explore implementation of a new crowd-out provision such as a waiting period with specific exceptions. At that time the State will also conduct a survey of the families with children who have lost coverage in the last six months to identify the reason for lost or discontinuance of coverage. The results from the survey will be used to define the possible exceptions to the newly imposed waiting period.

D. What have been the results of your analyses? Please summarize and attach any available reports or other documentation.

The percentage of children enrolled in the Program with prior creditable coverage in the last six months from October/2000 to October/2001 has ranged from a high of 3.51 in December 2000 to a low of 2.56 in October 2001. The supporting data is as follows:

Month	Number of CHIP II Approvals	Cumulative Total Approvals With Prior Coverage	Cumulative CHIP II Approvals	Percentage
November/ 2000	2,695	77	2,695	2.86
December	2,941	198	5,636	3.51
January/ 2001	2,867	292	8,503	3.43
February	1,749	348	10,252	3.39
March	2,740	419	12,992	3.23
April	2,460	485	15,452	3.14
May	2,554	542	18,006	3.01
June	2,314	585	20,320	2.88
July	2,384	645	22,704	2.85
August	2,073	694	24,777	2.80
September	2,852	750	27,629	2.71
October	3,327	793	30,956	2.56

E. Which anti-crowd-out policies have been most effective in discouraging the substitution of public coverage for private coverage in your SCHIP program? Describe the data source and method used to derive this information.

The State currently has no anti-crowd-out policies in place. Furthermore, according to data presented in Section D, the State is experiencing a high rate of substitution of public coverage for private coverage.

2.4 Outreach:

A. What activities have you found most effective in reaching low-income, uninsured children?

Personal contact outreach activities (e.g., face to face meeting and hands-on assistance provided by trained persons) have proved to be more successful in reaching low-income, un-insured children than non-personal contact contact activities (e.g.., radio and TV).

B. How have you measured effectiveness?

The evaluation of all outreach efforts was conducted by the private company. This is one of the findings listed in the final Mississippi Health Benefits Program Outreach Evaluation Report.

C. Have any of the outreach activities been more successful in reaching certain populations (e.g., minorities, immigrants, and children living in rural areas)? How have you measured effectiveness?

Survey data from the MHB Outreach Evaluation Report indicates Head Start Centers as being an effective place for consumers to receive information, but not effective in enrollment. Data is mixed in terms of identifying what is the most effective outreach strategy. The report also states that marketing the Program through private businesses, especially those in lower wage manufacturing operations as a company benefit , appears to stimulate additional program enrollment.

D. Which methods best reached which populations? How have you measured effectiveness?

Outreach strategies have been general in nature, not specific to any particular population. The Evaluation Report recommends targeted outreach activities as well as targeted media blitzs.

2.5 Retention:

A. What steps are your State taking to ensure that eligible children stay enrolled in Medicaid and SCHIP?

The Department of Human Services (DHS) is the state agency contracted with to determine eligibility for MHB. DHS has installed a new sub-system that enhances their ability to monitor and make changes relative to the enrollment and retention of cases.

The State also implemented passive re-determination in June 2001. The monthly notice cycle begins 45 days prior to the annual case review date. Three notices are issued in 10-day intervals. Cases in which a renewal is not received during the second ten-day period are issued a third and final notice.

The State is in the process of employing 47 outstationed eligibility workers in federally qualified health centers. These outstationed workers will not only enroll eligible children but will also have renewal cases to contact.

The State will continue to explore other initiatives (e.g. locating services of the Postal Service, provider-claims contact information, conducting focus groups with families who do not renew) to increase and retain enrollment of all eligible children.

B. What special measures are being taken to reenroll children in SCHIP who disenroll, but are still eligible?

__x__ Follow-up by caseworkers/outreach workers
__x__ Renewal reminder notices to all families
____ Targeted mailing to selected populations, specify population _____
____ Information campaigns
____ Simplification of re-enrollment process, please describe _____
____Surveys or focus groups with disenrollees to learn more about reasons for disenrollment, please describe_____
____ Other, please explain_____

C. Are the same measures being used in Medicaid as well? If not, please describe the differences.

Yes

D. Which measures have you found to be most effective at ensuring that eligible children stay enrolled?

Passive Re-determination - the family simply has to sign and return the renewal notice, if no changes have occurred. If changes have occurred, indicate the changes on the notice, sign and return it.

E. What do you know about insurance coverage of those who disenroll or do not reenroll in SCHIP (e.g., how many obtain other public or private coverage, how many remain uninsured?) Describe the data source and method used to derive this information.

No information is currently available. The State is planning to conduct focus groups with families whose children have become dis-enrolled.

2.6 Coordination between SCHIP and Medicaid:

A. Do you use common application and redetermination procedures (e.g., the same verification and interview requirements) for Medicaid and SCHIP? Please explain.

Yes, the same application, same application procedures and the same personnel are used in the application and redetermination process for Medicaid and SCHIP.

B. Explain how children are transferred between Medicaid and SCHIP when a child s eligibility status changes.

When an application is being reviewed by the eligibility worker at redetermination and the family s income exceeds the income limit for Medicaid, it is then assessed for CHIP eligibility.

C. Are the same delivery systems (including provider networks) used in Medicaid and SCHIP? Please explain.

No, all Medicaid providers are not CHIP providers; all CHIP providers are not Medicaid providers. Medicaid beneficiaries are assigned to primary care provider through HealthMacs, a state managed care program. CHIP beneficiaries receive services through an established commercial provider network.

2.7 Cost Sharing:

A. Has your State undertaken any assessment of the effects of premiums/enrollment fees on participation in SCHIP? If so, what have you found?

The State has secured the following information regarding cost sharing. As of July 2001, no family had reached the out of pocket maximum. Approximately forty households had accumulated in excess of $100 toward the household limit. No family had exceeded $200 toward the household limit. Since copayments and out of pocket expenses are assessed on a calendar year basis, further analysis will be performed after December 31st to evaluate any impact of cost sharing on enrollees/families.

B. Has your State undertaken any assessment of the effects of cost-sharing on utilization of health service under SCHIP? If so, what have you found?

Further evaluation of the effects of cost-sharing on utilization of health service under SCHIP is in process.

2.8 Assessment and Monitoring of Quality of Care:

A. What information is currently available on the quality of care received by SCHIP enrollees? Please summarize results.

DOM does capture service utilization data on enrollees. On site record reviews and audits are conducted with providers. An assessment of the percentage of Medicaid-eligibles 21 and under screened according to schedule has dropped significantly over the last year below 40%.

Relative to the children enrolled in CHIP II, preliminary utilization data from the insurer shows that 68% of children enrolled for just one month have received health care from at least one source. The longer the child is enrolled, the higher the rate of those seeking care: 80% of those enrolled for six months and 86% of children enrolled for twelve months received some type of health care service. (See graph for utilization statistics.)
From a match of CHIP enrollment data and the State Immunization Registry, 87% of children enrolled in CHIP had completed the required set of childhood immunization by 2 years of age.

B. What processes are you using to monitor and assess quality of care received by SCHIP enrollees, particularly with respect to well-baby care, well-child care, immunizations, mental health, substance abuse counseling and treatment and dental and vision care?

Ongoing reviews and audits of Medicaid service providers are conducted by nurses from DOM Bureau of Maternal Child Health.

For the CHIP II service providers, the insurer has quality assurance standards in place regarding the benefit structure. A number of covered services require prior authorization and others are only covered through case management. Certain services require medical necessary certification. Reviews of analyses of claims data, utilization management activities, appeals, nurse triage reports, etc., provide information for program interventions/implementation and planning for continual assessment/monitoring of quality of care issues.

C. What plans does your SCHIP program have for future monitoring/assessment of quality of care received by SCHIP enrollees? When will data be available?

The State plans to continue the above mentioned review and monitoring activities.

SECTION 3. SUCCESSES AND BARRIERS

This section has been designed to allow you to report on successes in program design, planning, and implementation of your State plan, to identify barriers to program development and implementation, and to describe your approach to overcoming these barriers.

3.1 Please highlight successes and barriers you encountered during FFY 2001 in the following areas. Please report the approaches used to overcome barriers. Be as detailed and specific as possible.

Note: If there is nothing to highlight as a success or barrier, Please enter NA for not applicable.

A. **Eligibility**

Parents of SCHIP enrollees are challenging the State to expand health coverage to them as well as dependent children who are still in school. Considering the current fiscal environment of the State, it is doubtful if any expansion of eligibility to any other group will occur.

B. Outreach

During FFY 2001, the CHIP staff was increased to four: the Administrator and three coordinators. Consequently the State was divided into four regional with a coordinator assigned to each area to provide Program education and technical assistance to the enrollees and the public and enhance and monitor outreach activities.

C. **Enrollment**

The State has implemented several changes in the enrollment process (e.g., optional self declaration of income, de-linking of child support activities from the application process) that had been reviewed as barriers.

D. **Retention/disenrollment**

The State implemented passive re-determination. The dis-enrollment rate is less than 30%. Current addresses on children at the time of renewal is a challenge.

E. **Benefit structure**

Dental benefits under CHIP II were considered quite limited, primarily preventive. Legislation was passed in the 2001 Legislature Session authorizing the expansion of

dental benefits. The expanded benefits were implemented January 01, 2002 and included some restorative, endodontic, periodontic, and surgical dental services.

F. **Cost-sharing N/A**

G. **Delivery system**

The State legislation that was passed to expand dental benefits also authorized the establishment of a dental provider network for CHIP II. At the end of September, a GeoAccess analysis showed that 99.9 % of CHIP II enrollees will have access to at least one dentist within 30 miles.

H. **Coordination with other programs N/A**

I. **Crowd-out N/A**

J. Other

The State is currently receiving technical assistance from Health Systems Research through a HRSA/CMS initiative called CompCare. The state team is composed of representatives from the Department of Health, the Department of Finance and Administration, DHS, and DOM. The focus of this initiative is to strengthen child health care systems. Health Systems Research is in the process of conducting an assessment of the enrollment process for MHB and conducting focus groups with uninsured families and families with children who have become dis-enrolled. The results from this effort will be made available possible by the end of the year.

SECTION 4: PROGRAM FINANCING

This section has been designed to collect program costs and anticipated expenditures.

4.1 Please complete Table 4.1 to provide your budget for FFY 2001, your current fiscal year budget, and FFY 2002 projected budget. Please describe in narrative any details of your planned use of funds.

Note: Federal Fiscal Year 2001 starts 10/1/00 and ends 9/30/01).

	Federal Fiscal Year 2001 costs	Federal Fiscal Year 2002	Federal Fiscal Year 2003
Benefit Costs			
Insurance payments	44,727,692	68,000,000	83,000,000
Managed care	- 0 -		
perper member/per month rate X # of eligibles	- 0 -		
Fee for Service	11,272,827	5,000,000,000	- 0 -
Total Benefit Costs			
(Offsetting beneficiary cost sharing payments)			
Net Benefit Costs			
Administration Costs	2,491,144	3,000,000	3,000,000
Personnel			
General administration			
Contractors/Brokers (e.g., enrollment contractors)			
Claims Processing			
Outreach/marketing costs			
Other			
Total Administration Costs	2,491,144	3,000,000	3,000,000
10% Administrative Cost Ceiling	5,598,798	3,771,715	3,791,715
Federal Share (multiplied by enhanced FMAP rate)	48,998,466	63,278,000	71,922,000
State Share	9,493,197	12,722,000	14,078,000
	58,491,663	76,000,000	86,000,000

4.2 Please identify the total State expenditures for family coverage during Federal fiscal year 2001.

4.3 What were the non-Federal sources of funds spent on your SCHIP program during FFY 2001?

_____State appropriations
_____County/local funds
_____Employer contributions
_____Foundation grants
_____Private donations (such as United Way, sponsorship)
_X_ Other (specify) MS Health Care Expendable Funds

A. Do you anticipate any changes in the sources of the non-Federal share of plan expenditures. No

SECTION 5: SCHIP PROGRAM AT-A-GLANCE

This section has been designed to give the reader of your annual report some context and a quick glimpse of your SCHIP program.

5.1 To provide a summary at-a-glance of your SCHIP program characteristics, please provide the following information. If you do not have a particular policy in-place and would like to comment why, please do. (Please report on initial application process/rules)

Table 5.1	Medicaid Expansion SCHIP program	Separate SCHIP program
Program Name		
Provides presumptive eligibility for children	__X__ No _____ Yes, for whom and how long?	__x__ No _____ Yes, for whom and how long?
Provides retroactive eligibility	_____ No __x__ Yes, for whom and how long? 3 months	__X__ No _____ Yes, for whom and how long?
Makes eligibility determination	_____ State Medicaid eligibility staff __x__ Contractor _____ Community-based organizations _____ Insurance agents _____ MCO staff _____ Other *(specify)* _____	_____ State Medicaid eligibility staff __x__ Contractor _____ Community-based organizations _____ Insurance agents _____ MCO staff _____ Other *(specify)* _____
Average length of stay on program	Specify months __12__	Specify months __12__
Has joint application for Medicaid and SCHIP	_____ No __x__ Yes	_____ No __x__ Yes
Has a mail-in application	_____ No __x__ Yes	_____ No __x__ Yes
Can apply for program over phone	__x__ No _____ Yes	__x__ No _____ Yes
Can apply for program over internet	__x__ No _____ Yes	__x__ No _____ Yes
Requires face-to-face interview during initial application	__x__ No _____ Yes	__x__ No _____ Yes
Requires child to be uninsured for a minimum amount of time prior to enrollment	__x__ No _____ Yes, specify number of months _____ What exemptions do you provide?	__x__ No _____ Yes, specify number of months _____ What exemptions do you provide?
Provides period of continuous coverage <u>regardless of income changes</u>	_____ No __x__ Yes, specify number of months __12__ Explain circumstances when a child would lose eligibility during the time period If child reaches age 19, move out of state, die or parents request.	_____ No __x__ Yes, specify number of months __12__ Explain circumstances when a child would lose eligibility during the time period If child reaches age 19 yeas, move out of state, die or parents request.

Table 5.1	Medicaid Expansion SCHIP program	Separate SCHIP program
Imposes premiums or enrollment fees	___X___No _____Yes, how much? _____ Who Can Pay? ___ Employer ___ Family ___ Absent parent ___ Private donations/sponsorship ___ Other (specify) _____	___x___No _____Yes, how much? _____ Who Can Pay? ___ Employer ___ Family ___ Absent parent ___ Private donations/sponsorship ___ Other (specify) _____
Imposes copayments or coinsurance	___x___No _____Yes	_____No ___x___Yes
Provides preprinted redetermination process	_____ No ___x___ Yes, we send out form to family with their information precompleted and: ___ ask for a signed confirmation that information is still correct ___ do not request response unless income or other circumstances have changed	_____ No ___x___ Yes, we send out form to family with their information and: ___ ask for a signed confirmation that information is still correct ___ do not request response unless income or other circumstances have changed

5.2 Please explain how the redetermination process differs from the initial application process.

At redetermination, a renewal notice with pre-printed information that was secured during the initial application process is sent to the family and they are asked to sign and return it if there are no changes. If there are changes, indicate the changes on the form, sign and return it. The completion of another application is not required unless the family fail to respond timely.

SECTION 6: INCOME ELIGIBILITY

This section is designed to capture income eligibility information for your SCHIP program.

6.1 As of September 30, 2001, what was the income standard or threshold, as a percentage of the Federal poverty level, for countable income for each group? If the threshold varies by the child s age (or date of birth), then report each threshold for each age group separately. Please report the threshold after application of income disregards.

Title XIX Child Poverty-related Groups or Section 1931-whichever category is higher	185% of FPL for children under age 1 yr 133% of FPL for children aged 1-6 yrs 100% of FPL for children aged 6-15 yrs
Medicaid SCHIP Expansion	100% of FPL for children aged 15-19 yrs ____% of FPL for children aged _____ ____% of FPL for children aged _____
Separate SCHIP Program	200% of FPL for children aged 0-19 yrs ____% of FPL for children aged _____ ____% of FPL for children aged _____

6.2 As of September 30, 2001, what types and *amounts* of disregards and deductions does each program use to arrive at total countable income? *Please indicate the amount of disregard or deduction used when determining eligibility for each program. If not applicable, enter NA .*

Do rules differ for applicants and recipients (or between initial enrollment and redetermination)

____ Yes __x__ No

If yes, please report rules for applicants (initial enrollment).

Table 6.2			
	Title XIX Child Poverty-related Groups	Medicaid SCHIP Expansion	Separate SCHIP Program
Earnings	$90/parent	$90/parent	$90/parent
Self-employment expenses	$	$	$
Alimony payments Received	$	$	$
Paid	$	$	$
Child support payments Received	$50	$50	$50
Paid	$	$	$
Child care expenses	$200/child under age 2 yrs; 175/child over age 2 yrs or dependent adult	$200/child under age 2 yrs; $175 /child over age 2 yrs or dependent adult	$200/child under age 2 yrs; $175/child over age 2 yrs or dependent adult
Medical care expenses	$	$	$
Gifts	$	$	$
Other types of disregards/deductions (specify)	$	$	$

6.3 For each program, do you use an asset test?

Title XIX Poverty-related Groups

_x_ No ___Yes, specify countable or allowable level of asset test_____

Medicaid SCHIP Expansion program

_x__ No____Yes, specify countable or allowable level of asset test_____

Separate SCHIP program

_x__ No____Yes, specify countable or allowable level of asset test_____

Other SCHIP program_____

____No____Yes, specify countable or allowable level of asset test_____

6.4 Have any of the eligibility rules changed since September 30, 2001? _X_ Yes ___ No

The six month waiting for eligible children with prior creditable health insurance was eliminated as of 10/01/2001.

SECTION 7: FUTURE PROGRAM CHANGES

This section has been designed to allow you to share recent or anticipated changes in your SCHIP program.

7.1 What changes have you made or are planning to make in your SCHIP program during FFY 2001(10/1/00 through 9/30/01)? Please comment on why the changes are planned.

A. Family coverage

B. Employer sponsored insurance buy-in

C. 1115 waiver

D. Eligibility including presumptive and continuous eligibility

Presumptive eligibility will be implemented on a pilot basis early 2002 with statewide implementation expected late April 2002.

E. Outreach

F. Enrollment/redetermination process

G. Contracting

H. Other